(b) A 1988 LOS adjusted case mix index shall be determined by multiplying the facility's 1988 distribution of patient within each LOS group determined pursuant to subparagraph (v) of this paragraph by the statewide average initial case mix index for each LOS group for the 1985 period, as determined pursuant to subparagraph (iii) of this paragraph, and dividing the sum of the results by the facility's total number of patients in all LOS groups, as determined pursuant to subparagraph (v) of this paragraph.

(c) The 1985 aggregate case mix index shall be subtracted from the 1988 LOS adjusted case mix index and the result divided by the 1985 aggregate case mix index to arrive at the percentage increase in case mix attributable to LOS.

(vii) An actual percentage increase in case mix shall, for each facility, be determined as follows:

(a) A 1985 actual case mix index shall be determined by multiplying the facility's 1985 distribution of patients, or a substituted 1985 distribution of patients where applicable, in each patient classification group as determined pursuant to subparagraph (iv) of this paragraph, by the case mix index for each patient classification group as contained in Appendix 13-A herein and dividing the sum of the results by the facility's total number of patients in all patient classification groups, as determined pursuant to subparagraph (iv) of this paragraph.

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(b) A 1988 actual case mix index shall be determined by multiplying the facility's 1988 distribution of patients in each patient classification group, as determined pursuant to subparagraph (v) of this paragraph, by the case mix index for each patient classification group as contained in Appendix 13-A herein and dividing the sum of the results by the facility's total number of patients in all patient classification groups, as determined pursuant to subparagraph (v) of this paragraph.

(c) The 1985 actual case mix index shall be subtracted from the 1988 actual case mix index and the result divided by the 1985 actual case mix index to arrive at an actual percentage increase in case mix.

(vill) Except as provided in subparagraph (ix) of this paragraph, a percentage recallbration adjustment shall be determined by annualizing the result obtained by subtracting the percentage increase in case mix attributable to DOS determined pursuant to subparagraph (vi) of this paragraph from the actual percentage increase in case mix determined pursuant to subparagraph (vii) of this paragraph from the actual percentage increase in case mix determined pursuant to subparagraph (vii) of this paragraph.

(ix) If a facility undergoes the appointment of a receiver or the establishment of a new operator on or after January 1, 1992 and files a new cost report in accordance with the provisions of section 86-2.10(k) of this Subpart which is used in the calculation of a revised payment rate, or for new facilities who receive an initial operating certificate on or after January 1, 1992, the percentage recalibration adjustment provided for in this subdivision shall be 0% for such revised payment rate or for such new facilities.

*The three-year effect of improved coding was annualized by taking the cube root of the three year accumulation factor.

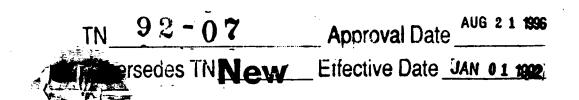
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- (3) The operating portion of each residential health care facility's rate of payment, as defined pursuant to paragraph (7) of subdivision (a) of Section 86-2.10 of this Subpart, shall be reduced by a per diem recalibration adjustment which shall be determined as follows:
- (i) The percentage recalibration adjustment identified in subparagraph (viii) of paragraph (2) of this subdivision shall be applied to the direct component of the rate determined in accordance with Sections 86-2.10 and 86-2.11 of this Subpart, to arrive at each facility's per diem recalibration adjustment in 1983 base year dollars.
- (ii) Each facility's per diem recalibration adjustment in 1983 base year dollars shall then be trended to the rate year by the applicable roll factor as defined in paragraph (8) of subdivision (a) of Section 86-2.10 of this Subpart.
- percentage recalibration adjustment greater than zero percent, as determined in subdivision (b) of this section, the percentage recalibration adjustment may be modified when conditions set forth in section 86-2.31(c)(1) are met. Additionally, a facility shall submit a modification request as an appeal application within the time limit set forth in section 86-2.13(a) of this Subpart.



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(ii) A facility shall document that the percentage change in the facility's reported case mix index (CMI) from the annual rate period 1985 through 1988, such percentage reduced by the percentage recalibration adjustment as determined by subdivision (b) of this section, is at least ten percent.*. The percentage change in the facility's reported CMI, for purposes of this subparagraph, shall utilize the CMI calculated from the facility's patient data obtained during the patient assessment period, March 1, 1985 through September 30, 1985, to the patient assessment period July 1, 1988 through December 31, 1988, conducted pursuant to section 86-2.30 of this Subpart, and shall be calculated by subtracting from the reported 1988 CMI, the reported 1985 CMI and the result divided by the reported 1985 CMI.

(iii) (a) Except as provided in clause (b) of this subparagraph, a facility shall document that the percentage change in direct care cost over trend from the annual rate period 1985 though 1988, as defined by those cost centers listed in subdivision (c) of section 86-2.10 of this Subpart, is at least ten percent. The percentage change in direct care cost over trend for purposes of this subparagraph shall be calculated by subtracting from the 1988 annual reported direct care cost, the 1985 annual reported direct care cost trended to 1988 by the applicable trend factors promulgated by the department for 1986, 1987 and 1988, and the result divided by the trended 1985 direct care cost. The annual reported direct care costs for 1985 and 1988, for purposes of this subparagraph, shall be those which the facility has submitted using the result of the single step-down method of cost allocation. **

*This means that the increase in reported case mix from 1985 to 1988, after subtracting out the recalibration adjustment for the facility, must be at least ten percent for the facility to qualify to possibly get a reduction in its recalibration adjustment.

**This refers to the allocation of the accumulated facility costs as reported via the RHCF cost reports into other cost centers that utilize their services. purpose of the step-down process is to finally consolidate reimbursable costs into the four components of the RHCF reimbursement rate for rate setting purposes. For example, costs reported under patient-specific services such as transportation, nursing administration and therapies, among others, are finally allocated to the costs contained in the direct portion of the rate.

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In the event a facility's facility-specific cost based direct price per day exceeds the facility-specific ceiling direct price per day, as determined pursuant to section 86-2.10(c)(4) of this Subpart, for the annual rate period 1988, such excess percentage shall be used to determine a credit to be added to the facility's percentage change in direct care cost over trend as determined in clause (a) of this subparagraph for the purposes of meeting the required percentage change in direct care cost over trend identified in clause (a) of this subparagraph. The amount of the credit shall be equal to such excess percentage if the facility documents that its percentage change in indirect care cost over trend from the annual rate period 1985 through 1988, as defined by those cost centers listed in subdivision (d) of section 86-2.10 of this Subpart, does not exceed its percentage change in direct care cost over trend for this period, as determined in clause (a) of this subparagraph, and if the facility cannot so document, the credit identified in this clause shall be reduced (but not be less than 0%) by the extent to which the percentage change in indirect care cost over trend exceeds the percentage change in direct care cost over trend. The percentage change in indirect care cost over trend for purposes of this subparagraph shall be calculated by subtracting from the 1988 annual reported indirect care cost, the 1985 annual reported indirect care cost trended to 1988 by the applicable trend factors promulgated by the department for 1986, 1987 and 1988, and the result divided by the trended 1985 indirect care cost. The annual reported indirect care costs for 1985 and 1988, for purposes of this subparagraph, shall be those which the facility has submitted using the result of the single step-down method of cost allocation.

(iv) Documentation shall be included in an appeal filed by the facility to the department that supports the reasons for the direct care cost increase which shall be based on increases in staffing levels and/or range and/or types of patient services. Increased direct care cost resulting



solely from an increase in the bed complement of a facility shall not constitute sufficient justification for granting a modification pursuant to this subdivision.

- (2) For a facility meeting all conditions specified in paragraph (1) of this subdivision, the modified percentage recalibration adjustment shall be determined as follows.
- adjustment shall be determined by annualizing the result obtained by subtracting the percentage change in the facility's reported CMI reduced by the percentage recalibration adjustment, as determined in subparagraph (ii) of paragraph (1) of this subdivision, from the percentage change in direct care cost over trend, as determined in subparagraph (iii) of paragraph (1) of this subdivision.
- (ii) The modified percentage recalibration adjustment shall be equal to the result obtained by subtracting the modification to the percentage recalibration adjustment, as determined in subparagraph (i) of this paragraph, from the percentage recalibration adjustment identified in subparagraph (viii) of paragraph (2) of subdivision (b) of this section.
- (iii) The modified percentage recalibration adjustment, as determined in subparagraph (ii) of this paragraph, shall not be less than 0%.

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APPLICATION OF 1992 RECALIBRATION APPEAL CRITERIA

EXAMPLE

ASSUMPTIONS

1	Reported	CMI Change, 1	985-1988		24	.44%
2	. Recalibra	ation % (Annua	lized)		7	40%
2	. Real CMI	Change, 1985-	1988		17	.04% (1-2)
		ost-Over-Trend		38		.71%
- 33		Cost-Over-Tre			•	.50%
- 83		ty Above Direc	······································			.9%
- 83					40	**************************************

APPLICATION OF CRITERIA

- Real CMI change (17.04%) meets 10% requirement
- Direct Cost-Over-Trend (8.71%) does not meet the 10% requirement.

However, since this facility is above ceiling on direct costs, a credit amount is determined, to be added to the direct cost growth of 8.71%.

CALCULATION OF CREDIT

- Excess of indirect Cost-Over-Trend compared to direct cost: 10.50% - 8.71% = 1.79%
- Credit Amount: 20.9% 1.79% = 19.11%
- Direct Cost-Over-Trend: 8.71% + 19.11% = 27.82% with credit

CALCULATION OF MODIFIED RECALIBRATION

Since the revised value of direct cost growth with the credit (27.82%) exceeds the 10% requirement, facility qualifies for a modification, subject to appropriate documentation showing that direct care cost increases were due to increases in staffing levels or range/types of services.

Modification Value # 27.82% - 17.04% # 10.78%

(Dir. cost) - (real CMI change)

This is then annualized, giving 3.47%

Modified Recalibration Adjustment = 7.40% - 3.47 = 3.93%

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86-2.33 Dementia Pilot Demonstration Projects. (a) Payment rates shall be adjusted by the addition of a per diem amount as determined by the commissioner pursuant to this section for residential health care facilities participating in pilot demonstration projects for the development of additional knowledge and experience in the area of dementia care and to improve the quality of care and treatment of patients with dementia.

- (b) The adjustment to payment rates provided for in this section shall be made for qualifying residential health care facilities (RHCFs) applying for and receiving the approval of the commissioner for participation in such projects. Acceptable uses of such adjustment shall include but shall not be limited to:
 - (1) increasing the availability of programs and resources for dementia patients:
 - (2) training staff to manage behavior or promote effective care of dementia patients;
 - (3) arranging the environment in ways that produce positive outcomes for dementia patients; and/or
 - (4) maintaining and promoting autonomy and decision-making on the part of dementia patients.
- (c) Individual facilities or groups of facilities may participate in pilot demonstration projects pursuant to this subdivision.

TN No. 88-34 supercedes
TN No. ----

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